

**AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND  
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

General exclusions and limitations applicable to the amount, duration and scope of medical and remedial care and services provided under this State Plan.

On behalf of the categorically needy, only reasonable costs or reasonable charges as applicable for medical or remedial care will be paid when the items of care furnished are medically necessary for diagnosis, treatment, or both, subject to exclusions and limitations applicable to specific services and third party liability.

The benefits of this program do not extend to:

- o Any recipient who is an inmate in a public institution (except as a patient in a medical institution) except as provided for in this State Plan.
- o Special shoes or other supportive devices for the feet, ambulation aids (except as approved and prior authorized as a home health care benefit under such program), or immunizations (except medically necessary influenza and pneumonia immunizations).
- o Any services actually provided by military medical facilities (except for those military hospitals enrolled to provide inpatient emergency services), Veterans Administration facilities, or United State Public Health Service Hospitals.
- o Care and treatment related to any condition for which benefits are provided or available under the Workmen's Compensation Laws.
- o Care, treatment or other services by a Doctor of Dental Surgery or Doctor of Dental Medicine. Essentially this means that services related to teeth or structures directly supporting the teeth or other services provided by a dentist are not covered except as described and limited elsewhere in this State Plan.
- o Any care or services to the extent that a benefit is paid or payable by Medicare.

A				
STATE	DATE REC'D	DATE APP'D	DATE EFF.	HCFA 179
<i>Topas</i>	<i>10-21-93</i>	<i>1-13-94</i>	<i>10-1-93</i>	<i>93-32</i>

TN No. 93-32  
 Supersedes 89-18 Approval Date 1/13/94 Effective date 10/1/93  
 TN No. 89-18

- o Any services or supplies rendered to a Medicaid recipient before the effective date of his designation by the single state agency as a recipient or after the effective date of his denial as a recipient.
- o Any services or supplies rendered in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member or when specially authorized by the single state agency.
- o Any services or supplies rendered in connection with a routine physical examination except when rendered in connection with family planning services.
- o Any services rendered by an immediate relative of the recipient or member of his household.
- o Any services or supplies which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, except family planning and cosmetic surgery when authorized specially by the single state agency, or except as otherwise specified in this plan.
- o Any services or supplies rendered to a recipient after a finding has been made under Utilization Review procedures that such services or supplies are not medically necessary.
- o Any services or supplies provided outside of the United States, except for deductible and co-insurance portions of Medicare benefits as provided for in this plan.
- o Any services or supplies to the extent that benefits are available for such services or supplies under any other contract or policy of insurance, or would have been so available in the absence of this contract.
- o Self-administered drugs except for those provided under the vendor drug program or as otherwise specified in this plan.
- o Any take-home items or drugs except for those provided under the vendor drug program or as otherwise specified in this plan.

A	
STATE	DATE REC'D
Texas	MAR 31 1994
	DATE APPE'D
	MAY 09 1996
	DATE EFF
	JAN 01 1994
	HCFA 179

TN No. 94-10Superseded by Approval Date MAY 09 1996TN No. 87-18Effective date JAN 01 1994

- o Benefits to an individual for the diagnosis or treatment of mental disease, psychoneurotic, and personality disorders while not confined as an inpatient in a hospital which exceed 30 visits to enrolled practitioners per calendar year. This utilization control limitation may be exceeded when prior authorized on a case by case basis.
- o Services provided by ineligible or suspended providers.
- o Any service or supplies not specifically provided by the Texas Medical Assistance Program.
- o Any service or supplies for which claims were not submitted within the filing deadline.

STATE <u>Texas</u>	A
DATE REC'D <u>2-18-94</u>	
DATE APP'D <u>3-25-94</u>	
DATE EFF <u>2-1-94</u>	
HCFA 179 <u>94-01</u>	

TN No. 94-01  
Supersedes 88-21 Approval Date 3/25/94 Effective Date 2/1/94  
TN No. 88-21